Developing Health Goals and A Comprehensive Health Strategy for Nova Scotia

A Discussion Paper

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Provincial Health Council

Preface

This paper is offered to the people of Nova Scotia by the Nova Scotia Provincial Health Council.

It is presented in draft form. We hope that public discussion and debate will be stimulated and that there will be consensus among the people of the province about our goals for the future of health and health care.

Developing health goals is just the beginning of a much larger process. Next, we must establish short and medium-term objectives in pursuit of goals, and decide which issues will be our highest priorities.

We need to plan the future of health and health care together. Change is occurring. You can be part of it. The Nova Scotia Provincial Health Council is here to provide leadership in that change and to invite your participation in it.

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There has been substantial documentation about health and the health care system in Nova Scotia over the past couple of years. As a result, change has already taken place in the way the system is planned. The establishment of the Provincial Health Council is one example of that change.

The Council's mandate – to engage the citizens of Nova Scotia in planning the future of health and health care and then provide advice to the Minister of Health on ways to improve the system – involves the development of provincial health goals. This is consistent with the recommendations regarding a "New Health Strategy" which were made by the Nova Scotia Royal Commission on Health Care, and the Government of Nova Scotia's response to it, *Health Strategy for the Nineties.*

The Provincial Health Council is therefore offering Nova Scotians a definition of health, a Comprehensive Health Strategy and draft health goals for review.

Our definition of health refers to health as the capacity to function optimally and to achieve well-being. This definition implies that "health" is more than merely "not being sick", and is affected by many things such as where people live, how much money they have, their genetic inheritance, whether they live and work in safe and healthy environments, and how well educated they are.

This very broad definition of health leads to a Comprehensive Health Strategy, which has nine parts:

A. Health Status Enhancement Policies.

B. Health Care Policies.

C. Social Policies.

D. Physical Environmental Policies.

E. Collaboration and Participation Policies.

F. Technology Assessment Policies.

G. Innovation and Evaluation Policies.

H. Intergovernmental Policies.

I. Resource Allocation and Acquisition Policies.

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Building on this Comprehensive Health Strategy, Council is proposing the following draft health goals:

Environment – To preserve and enhance the physical environments of Nova Scotia to make all aspects of living supportive of health.

Governance – To ensure that Nova Scotians meaningfully participate in the development of and decisions about public policies and programs that affect health and the health care system.

Health Status – To improve the health of Nova Scotians through a decrease in preventable illness, injury, and premature death and through the enhancement of markers of well-being.

Individual – To enhance the capacity of Nova Scotians to understand and favourably influence the factors that affect health.

Resources – To ensure that appropriate public resources, as determined by Nova Scotians, are allocated to the achievement of health goals and are managed in a fair, effective and efficient manner.

Social – To strengthen the capacity of Nova Scotia to ensure social justice and provide adequate opportunities to achieve equity in health.

Following the process of getting input from Nova Scotians on these draft health goals, Council will offer the final health goals to the Minister of Health. Then we will have to work together to develop short and medium-term objectives in pursuit of goals, and to reshape the future of health and health care in our province.

What Health Goals Are All About...

Developing Health Goals For Nova Scotia Questions and Answers

What Are Health Goals?

Health goals are broad statements of what we want "health" and "health care" to be like in Nova Scotia. They also establish the scope of comprehensive health planning, which involves much more than the traditional health care system.

In pursuit of our health goals, specific and measurable short-term and medium-term objectives will need to be established. However, these specific objectives should not be confused with the general and long-term health goals themselves. Our health goals will indicate a desired direction, not a fixed target; specific objectives, changing over time, will measure our progress.

Why Are Health Goals Needed?

Health Goals will help provide a framework for making major improvements and ongoing changes to health and health care in the province. These goals will also provide a set of guideposts to help measure the progress made in improving the health of Nova Scotians in the short and long-term.

How Will Health Goals Be Developed?

In response to the recommendations of the Royal Commission on Health Care the Provincial Health Council was established by the Government of Nova Scotia in December 1990. One of its first major tasks is to advise the government on provincial health goals and a comprehensive health strategy. This will be possible after extensive consultation with Nova Scotians in the spring of 1992.

To facilitate this process, the Council is sending copies of the present Discussion Paper to as many agencies, associations and government departments as possible. These organizations are being asked to provide written responses on these draft health goals. [A summary version of this discussion paper is also available. Please contact the Provincial Health Council for more information].

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In addition, the Council is holding a number of meetings across the province to encourage and receive reactions from the citizens of Nova Scotia on the draft health goals. The Council especially wants to meet with Nova Scotians who are not involved in formal or organized health-related groups, but who have an interest in what happens to our health system.

How Will Having Health Goals Make A Difference

Until now, there have never been formally elaborated health goals for Nova Scotia. Having goals which are the product of extensive public input will lay the foundation for a more detailed plan for the future. They will also help people involved with health, at the provincial, regional and local levels, to make better decisions in their planning.

Such decisions should be consistent with our collective vision of a health system. Then they can be evaluated by the public and providers alike.

Health goals will also provide direction to the work of Regional Health Agencies when they are established.

What Happens After Health Goals Are Finalized?

After the public consultations, the draft health goals will be finalized and presented to the Minister of Health.

In defining health goals, we tend to employ words like 'enhancement', 'improvement', and 'strengthening'. In the long run, health goals represent a constant challenge to do better. They represent a desired direction, not a final target.

In the pursuit of health goals we will establish a range of specific objectives reflecting direct, measurable changes we intend to make. These shorter-term objectives will be established in consultation with Nova Scotians, and with progress they will change over time.

Why Is It Important That I Get Involved?

Health goals are not made for Nova Scotians - they are made *by* Nova Scotians.

It is vital that as many individuals and organizations as possible get involved in the process of developing health goals that reflect the collective values of the people of Nova Scotia. If you do not participate in this decision-making process, you will not be part of directing the change that is going to happen to health and health care for you, your family, your community and your province.

How Can I Participate?

There are several ways you can get involved.

As an individual, you can call the Provincial Health Council at 424-7155, or 1-800-665-7155, toll-free, to receive as many copies of this Health Goals Discussion Paper (or the shorter Summary Version) as you, your friends and family need.

At the back of each paper are five questions that we are asking about the draft health goals. You can write down your ideas and send them to us, or talk to us on the telephone, or invite us to meet with a group in your community or workplace.

You can also come to the Health Goals meeting that is being held in your area. Information on the location and date of each meeting will be available from the Provincial Health Council Office, and will also be printed in most newspapers.

As a member of a group or organization, you may want to provide comments to us through your association.

How Can I Contact The Provincial Health Council?

If you want to write to us, our address is:

Provincial Health Council, 1660 Hollis Street, Suite 406, Halifax, N.S., B3J 1V7 424-0598 (fax)

If you want to phone our office, you can call 424-7155 or 1-800-665-7155 toll-free and ask for Mary-Jane Hampton, Ian Johnson, Karen McNutt or Heather Praught. Any member of our staff will be pleased to talk with you about the health goals and how you can get more information.

You can also get in touch with the member of the Provincial Health Council closest to you by contacting the Provincial Health Council office:

Council Members for each area are:

Gwen Haliburton,	Chairperson Dartmouth
Ruby Blois	Dartmouth
Bertha Brannen	Yarmouth County
John Cochrane	Kentville
Doug Crossman	Dartmouth
Joan Glode	Shubenacadie
Lynn McIntyre	Halifax
John Oss	Shelburne
Father Michael Rankin	Sydney
Judith Ritchie	Halifax
Brenda Van Zoost	Amherst
Dolly Williams	East Preston

We look forward to hearing from you.

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What Does "Health" Really Mean?

Defining Health

The Nova Scotia Provincial Health Council felt it would be helpful to review the various stages through which the definition of health has progressed in order that the rationale supporting our definition be understood.

Health is determined, in part, by inherited susceptibility to disease and how individuals respond to disease or disability. For people who have a strong constitution and a positive outlook, disease may have a minimal impact. For others, stress and limited social support may increase the risk of developing disease and promote suffering. Differences in health status also appear to result from many factors including childhood experience, workplace hazards, position in the work hierarchy and exposure to a toxic physical environment. People with low incomes often have limited support systems and lack the capacity to cope with their own life stress and that of family members.

We know, however, that the most important factors that determine one's health are how much money they have, where they live and their level of education. The development and maintenance of good health therefore requires more than just a good health care system. Healthy individual lifestyles, safe and supportive families and communities, meaningful employment opportunities, social justice and economic prosperity are all factors which have been linked in previous studies to good health. Appropriate housing, transportation, income support, and environmental protection also have a significant influence upon health. In other words, we must develop healthy public policy.

In 1974, the federal government of Canada published "A New Perspective on the Health of Canadians", which identified the important role that social and physical environments, lifestyle and behaviour play in determining individual's health. Since that time, further research has identified other important factors which affect health, such as economic well-being, early childhood experience and the workplace environment.

As such the definition of health has evolved from:

> "...The overall sound condition or function of a living organism at a particular time; freedom from disease or defect." (*Webster's Dictionary*)

...To a recognition of the social and economic elements which influence how healthy we are:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (*World Health Organization - The Constitution of the World Health Organization WHO Chronicles*, 1947; 1:29)

...To a more holistic balance with the factors which influence life and living:

> "It is the extent to which an individual or group is able, on the one hand, to develop aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities." (*Health Promotion: a discussion document on the concept and principles*, Copenhagen: WHO Regional Office for Europe 1984.)

Health defined in the broader context is no longer merely the absence of disease, but is a positive resource which allows people to cope with, adapt to and influence the pressures of daily living. It is not only an objective to be sought or a result of a health care system, but an asset for living and achievable by all.

So health is regarded as a complex phenomenon with physical, mental and social components, the attainment of which depends on the organism successfully making a continuous effort to adapt to its environment. (Ref: Dubus, R., *L'Homme et l'adaptation au milieu*. Paris, Pugot, 1973.) Poor health is thus the result of an imbalance caused by either a deficiency in the organism or an unfavourable environment.

Contemporary definitions also embrace the individual, the environment and the broader community in their framework:

> "...Being fully alive – physically, mentally, spiritually and emotionally and being connected in a fulfilling way with the natural and human world that surrounds us." (Duhl, L. Et al. *In the Time of the Parenthesis. The Entrepreneurship of Change.* Chapter 5, p.3 (manuscript). Quotations cited in: Gail Siler-Wells. "Public Participation in Community Health." Health Promotion, Summer 1988, pp.7-11, 23)

We may also consider the inclusion of "joy, belonging, participation, living, learning and loving".

In two respects the fundamental change in the concept of health has presented a major challenge to the health care system, its planners and policy makers. First, in addition to continuing to treat illness and injury, increased emphasis has been placed on health promotion and disease prevention in an effort to address the underlying factors which contribute to the development of health problems. The second impact has been the need to focus on issues such as the environment and the economic status of individuals which, while very important determinants of health, are beyond the immediate control of the health care system. Indeed we are forced to consider planning and policy issues from two very different perspectives: health and health care. At the same time individuals have begun to assume more responsibility for their own health through an improved lifestyle which involves a proper diet, exercise, the elimination of smoking and the reduced consumption of alcohol. Environmental awareness has also become a growing trend in Nova Scotia and Canada.

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The Nova Scotia Provincial Health Council's Definition of Health

Consistent with this emerging view of health and seeking to capture its broad and holistic implications, the Nova Scotia Provincial Health Council has adopted the following working definition of health:

"Health, for Nova Scotians, is the capacity, as individuals and as members of groups and communities, to function optimally and to improve their social and physical environments to achieve well-being."

In simpler terms...

"Health is the capacity to function optimally and to achieve well-being."

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The Future of Health and Health Care

A Comprehensive Health Strategy For Nova Scotia

I. Introduction

Both the *Report of the Nova Scotia Royal Commission on Health Care* and the Government of Nova Scotia's *Health Strategy for the Nineties* have called for fundamental changes in the definition of health and how the health care system operates (Province of Nova Scotia, *Report of the Royal Commission*, 1989; Province of Nova Scotia, *Health Strategy for the Nineties*, 1990).

The Royal Commission's *Report* urged the development of a new strategy that would be more appropriately aimed at improving the health of Nova Scotians. It set out five Guiding Principles that would form the basis of this New Health Strategy:

Health policies oriented to healthy outcomes.

Participation of citizens.

Decentralization and regionalization.

Accountability.

Matching resources to local health needs.

The Commission also identified four underlying values upon which Comprehensive Health Policies should be based:

Equity (that is, every person having an equal opportunity for achieving and maintaining good health).

Participation (that is, the opportunity for all concerned individuals and organizations to be able to participate in planning new health policies).

Intersectoral Approach (that is, the recognition that health is affected by many different factors and thus requires a coordinated approach by all levels of government and other relevant bodies).

Ecological Perspective (that is, health must be viewed from a broad perspective and linked to both the social and physical environments).

In keeping with the recommendations of the Royal Commission and *Health Strategy for the Nineties*, the Government of Nova Scotia established the Nova Scotia Provincial Health Council to advise the government on a Comprehensive Health Strategy and to recommend health goals and objectives for the province. In addition, the Council will also provide advice on how these goals can be achieved.

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In September 1991, the Council adopted the following working definition of health in recognition of the major changes recommended in the *Report of the Royal Commission* and the government's own *Health Strategy:*

> "Health, for Nova Scotians, is the capacity, as individuals and as members of groups and communities, to function optimally and to improve their social and physical environments to achieve well-being."

With this definition in hand, the Council is anxious to fulfil its main responsibility of recommending health goals and a Comprehensive Health Strategy. A Comprehensive Health Strategy will consist of several general policies for a number of key areas or components. These will provide guidance for the development of more specific policies. This paper is intended to provide the framework within which such planning can occur.

In this paper, the key components of a Comprehensive Health Strategy are outlined. It is hoped that this paper generates widespread discussion about the breadth and content of such a strategic framework and the specific policies that are needed to facilitate and implement it.

In presenting this discussion paper, the Council is aware of at least three other major public policy development exercises that have been undertaken in the province. During the past three years, Voluntary Planning has overseen the preparation of a new economic strategy for Nova Scotia (Voluntary Planning, 1991). During the past two years, the Nova Scotia Round Table on Environment and Economy has been working to finalize a Sustainable Development Strategy (Nova Scotia Round Table, 1991). During the past year, the Department of Natural Resources (formerly the Department of Mines and Energy) has produced a new provincial energy strategy (*Nova Scotia Energy Strategy,* 1991).

These documents will ultimately have major implications for the development of a Comprehensive Health Strategy and it is hoped that they will all be complementary, or at least cognizant of one another. One element that is common among all three sets of policies is, as the Nova Scotia Economic Strategy document concludes, "The only certainty is that the status quo is no longer an option."

II. The Vision (Values, Goals and Objectives)

Values, goals, objectives, and strategy all link together to form a vision of how health and health care should be planned and achieved. It offers the inspiration or the ideal towards which progress can be measured, especially for a Comprehensive Health Strategy.

Thanks to the medicare pioneers in Saskatchewan and those at the federal level, there was a vision expressed by the federal Royal Commission on Health Services in 1964, "that as a nation, we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind," (Government of Canada, *Royal Commission,* 1964). In 1972, a group of senior

provincial government officials produced an ideal health services system (Government of Canada, *The Community Health Centre in Canada,* 1972). Despite the success of the medicare system in making illness care accessible, the health status of Nova Scotians suggests that the singular focus on illness care is insufficient. Despite calls for reforms since the early 1970's, no real change has occurred. The Royal Commission, in 1989, emphasized the need for a revitalization of health care in Nova Scotia through a New Strategy for Health which would include health goals and specific objectives (Province of Nova Scotia, *Report of the Royal Commission,* 1989).

However, prior to developing goals and objectives, there is a need to clarify Nova Scotia's underlying values and principles of health. From the start of medicare, there have been five basic program conditions: universality, accessibility, comprehensiveness, portability and public administration. As mentioned earlier, the Royal Commission outlined five guiding principles to achieve a new health strategy: health policies oriented to healthy outcomes, participation of citizens, decentralization and regionalization, accountability, and matching resources to local health needs. These new health policies would be based on four values: equity, participation, an intersectoral approach, and an ecological perspective (Province of Nova Scotia, *Report of the Royal Commission,* 1989).

[Please see Appendix A for the health goals and objectives recently set by other provinces.]

III. Overview of Key Components

As described earlier, there is a fundamental shift taking place in how health and health care are being viewed. Health is now clearly understood as being much more than the absence of disease. It is linked to, and affected by, changes in our social and physical environments, and is determined greatly by factors which lie outside the health care system.

As summarized by the *Premier's Council on Health Strategy in Ontario,* a growing body of research has identified a long list of important factors in the social environment that influence the health status of individuals. These include such factors as early childhood experience, workplace hazards, family and friendship supports and employment status (Province of Ontario, Premier's Council, 1991). It is also increasingly understood that the linkages between these factors and health are complex and that the various sectors of our society are interconnected and even interdependent (Government of Canada, Health and Welfare Canada, Health Services and Promotion Branch, 1988). One other important finding is that increased expenditures on health care do not automatically translate into improvements in overall health status of a population.

At the same time, it is generally recognized that there is a health gap in terms of life expectancy and death rates between lower socio-economic groups and higher socio-economic groups. While medicare has helped to improve access to medical care, it has had limited impact on changing the differences in health status according to socio-economic status (Government of Canada, National Council on Welfare, 1990). It is therefore insufficient to

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focus mainly on changing individual lifestyles. Health inequalities and social justice concerns deserve equal attention.

While it is apparent that improvements are needed in our present health care system, it is also clear that healthy public policies (or public policies for health) are actually more essential if the root causes of ill health are to be addressed and well-being is to be achieved. The development of such policies suggests the need for close collaboration and coordination among a wide range of departments and agencies. This must be part of an open and active process to encourage and maintain public participation at all levels of health policy planning.

These conclusions about the current agenda and approach for health policy development suggest that a Comprehensive Health Strategy for Nova Scotia which is guided by a vision (values, goals and objectives) should include the following key components:

A. Health Status Enhancement Policies (that is, policies needed to guide the collection of health status information and to help improve health status).

B. Health Care Policies (that is, policies needed to reshape or reform the health care system as recommended by the Royal Commission and outlined in *Health Strategy for the Nineties*).

C. Social Policies (that is, policies needed to address the health consequences of poverty, unemployment and other social and community issues).

D. Physical Environmental Policies (that is, policies needed to address the health consequences of physical environmental issues, including occupational health and safety).

E. Collaboration and Participation Policies (that is, policies needed to encourage close collaboration among providers, and with broad-based participation by the public).

F. Technology Assessment Policies (that is, policies needed to help make decisions about the appropriate availability and use of health technology).

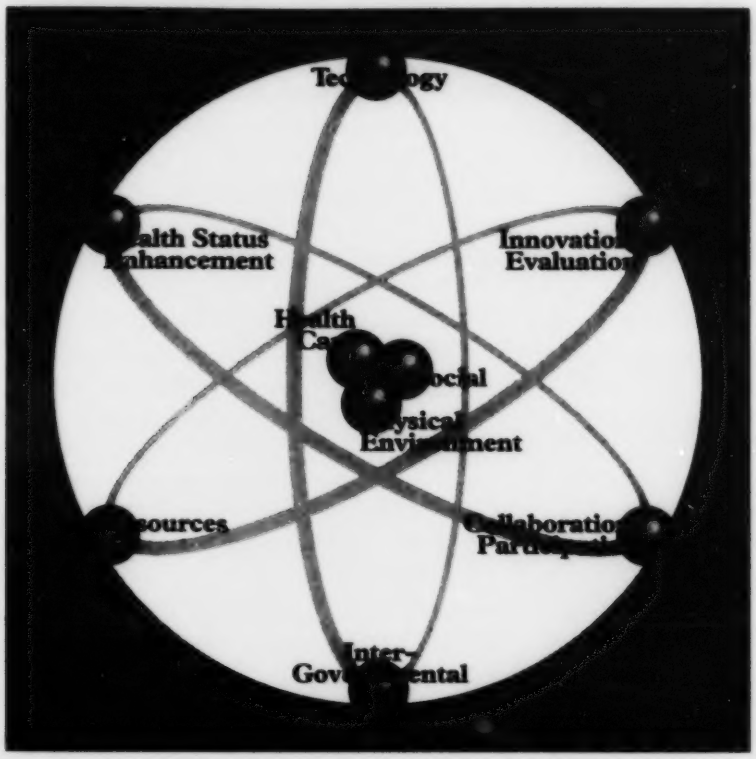
G. Innovation and Evaluation Policies (that is, policies to encourage and sustain innovation and evaluation activities in health).

H. Intergovernmental Policies (that is, policies needed at national, interprovincial and provincial-municipal levels to improve health).

I. Resource Allocation and Acquisition Policies (that is, policies needed to guide decisions about the allocation and acquisition of resources for health).

The Strategy and its key components are illustrated in the diagram on the following page. This diagram shows a dynamic interrelationship between and among the nine components within an overall vision, and suggests how it can be used for the development of a wide range of health-related policies.

Comprehensive Health Strategy



A Comprehensive Health Strategy Involves Developing, Implementing and Assessing Policies Within a Broadly Defined Vision

A. Health Status Enhancement Policies

As envisioned by the Royal Commission, a New Strategy for Health would require, at least in part, health policies oriented towards healthy outcomes and matching resources to health needs (Province of Nova Scotia, *Report of the Royal Commission,* 1989). To this end, there must be both the capability to monitor the health status of Nova Scotians on a continuous basis and a commitment to develop policies that will help to enhance or improve health status.

Nova Scotians fare poorly on almost any commonly used measure of health status compared to other Canadians. The overall mortality and disability rates for Nova Scotia are the highest in Canada. Nova Scotia has one of the highest incidences of premature death in the country as a percentage of all deaths.

Nova Scotian males have higher death rates than the national average for four of the leading causes of death in Canada: heart disease, cancers, accidents and cerebrovascular diseases. Nova Scotian females have higher death

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rates than the national average for three of the leading causes of death: heart diseases, cancers and respiratory diseases (Province of Nova Scotia, *Health Strategy for the Nineties*, 1990; Province of Nova Scotia, *Report of the Royal Commission*, 1989).

Besides these more traditional health status indicators, various behavioural measures suggest that Nova Scotians will continue to be at risk if current lifestyles and underlying social and environmental factors are not changed. Higher levels of blood pressure, smoking and obesity combined with lower rates of physical activity have been recorded among Atlantic Canadians in general and Nova Scotians in particular. For example, the percentage of women who are regular smokers and consume alcohol on a weekly basis has been found to be higher than the national average (White, 1985; Province of Nova Scotia, *Report of the Royal Commission*, 1989).

Recent trends among young people are comparable for these broader behavioural patterns. In its April 1991 survey, Drug Dependency Services of the Department of Health reported that at least half of the 3,400 Grade 7, 9, 10 and 12 students contacted had tried smoking tobacco, with almost one in five smoking at least one cigarette daily. In addition, the survey found that three out of every four said they had consumed alcohol at least once in the last twelve months and more than one in four said they drank regularly, that is, at least twice a month (Drug Dependency Services, 1991).

While these indicators paint a disturbing picture, it is widely acknowledged that there are many weaknesses in our understanding of the health status of Nova Scotians. Consultants for the Royal Commission identified several major gaps in health status data such as population-based health status data, the factors behind the leading causes of mortality and morbidity, high-risk groups and mental health data (Tregunna, et al., 1989). Following her review of the limited health status data available for the province, Dr. Lynn McIntyre called for a provincial health profile which would be able to present at least five years of data at both the county and health unit levels (McIntyre, 1990).

B. Health Care Policies

As stated earlier, the Royal Commission Report and *Health Strategy for the Nineties* identified the need for fundamental changes in the health care system (Province of Nova Scotia, *Report of the Royal Commission*, 1989; Province of Nova Scotia, *Health Strategy for the Nineties*, 1990). While there are differences between the two documents, together they have indicated the areas in the health care system where new policies are needed:

A greater emphasis on primary health care, health promotion and community health programs.

Broad public and provider participation in health planning and management through such means as the establishment of a Provincial Health Council and regional health bodies.

The restructuring of the Department of Health with regionalization and possible decentralization of health planning and services.

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At the least, a major assessment of the supply, mix, remuneration and training of health professionals.

At the least, a review of other key health services besides acute care, such as coordinated home care, community mental health services and long-term care services.

Since the release of these reports, some progress has been made on these new policy directions. At the time of writing, the Provincial Health Council has been established, the Department of Health has undergone some major internal structural changes, several task forces have been set up or are about to get underway, a Community Health Promotion Fund has been established and some demonstration projects involving community-based primary health care have been announced or started.

Yet to occur is the development of alternative, community-based health care services and facilities so that the optimal use of the traditional system is achieved and medical and hospital-based services are used much more effectively and efficiently. A number of studies have shown that as much as 20 to 30 per cent of hospital services are used inappropriately (Hall, 1980; Fyke and Poole, 1991). In fact, both the Royal Commission and *Health Strategy for the Nineties* reported that the average occupancy rate of hospital beds in Nova Scotia is well below the national figure. This suggests a surplus of beds in this province (Province of Nova Scotia, *Report of the Royal Commission,* 1989; Province of Nova Scotia, *Health Strategy for the Nineties,* 1990). Hospital lengths of stay, in some parts of the province, are also considerably longer than the national norm.

A Legislative Select Committee on Health, in 1985, and the Royal Commission, in 1989, both recommended that the number of services insured under the provincial Medical Services Insurance (M.S.I.) plan be expanded (Nova Scotia Legislative Select Committee, 1985; Province of Nova Scotia, *Report of the Royal Commission,* 1989). These services would include Pharmacare, technical aids for persons with disabilities, and broadened eligibility for admission into the Coordinated Home Care Program.

C. Social Policies

As stated earlier, there is a health gap between persons in low-income groups and those in higher-income groups in Canada. Research cited by the Premier's Council in Ontario shows that life expectancy is greater in developed countries with a narrow range between lowest and highest income groups, such as Japan and the Scandinavian countries, than in countries with a wider gap such as the United States, which has higher per capita incomes (Premier's Council, 1991).

There are several indicators which show there are a sizeable number of low-income persons in Nova Scotia. Based on the latest Statistics Canada estimates, 15.4 per cent of families and 33.9 per cent of unattached individuals were considered to be of "low-income" in Nova Scotia in 1990. This compares to 12.2 per cent of families and 31.1 per cent of unattached individuals nationally (Statistics Canada, 1991). As well, the average minimum wage in Canada, which is about $5.16 an hour ($5.00 an hour in Nova Scotia as of

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January 1, 1992), is only about 70 per cent of the poverty line. Since the Atlantic Region has a greater proportion of low-wage earners (most of whom are women), it is likely that the percentage of low-income workers falling below the poverty line is even greater in this province than on the national level (Hess, 1991). Statistics Canada figures also indicate that 15.7 per cent of children under the age of 18 were living below the poverty line in Nova Scotia in 1989, as compared to 14.5 per cent nationally (Statistics Canada, 1989).

To make matters worse, the number of unemployed persons in Nova Scotia has been steadily increasing during the past year. In 1991, the average number of unemployed persons (seasonally adjusted) for the province was 52,000 as compared to 46,000 in 1990. The average unemployment rate (seasonally adjusted) for the province was 12.3 per cent in 1991, compared to 10.7 per cent in 1990 (Statistics Canada, *Historical Labour Force*). These increases in unemployment for 1991 over 1990 reflect, at least in part, the closures or downsizing of many cornerstone businesses around the province in such industries as fishery, forestry, mining and manufacturing, that have taken place during the current recession.

In addition, the Nova Scotia Association of Social Workers reported in 1990 that all persons receiving municipal social assistance are living below the poverty line and that, at best, the maximum rates of assistance in Halifax County were 30 per cent below the poverty line and at worst, in Kings County, they were 58 per cent below the poverty line (N.S.A.S.W., 1990). On a national level, only three provinces (not including Nova Scotia) raised social assistance rates in 1990 more than inflation (National Council on Welfare, 1991).

This means that fewer and fewer Nova Scotians are able to make ends meet and cover basic living costs. For example, Canada Mortgage and Housing Corporation (CMHC) estimated that, in July 1990, almost 20 per cent of all Nova Scotian households were paying more than 30 per cent of their annual household income for housing, or were living in inadequate housing, or both (Wanzel and Wrathall, 1991).

Children are particularly vulnerable to a downturn in the economy and reduction in household incomes. As reported by the Premier's Council on Health Strategy in Ontario, Canada has a higher ratio of children born with low birth weights than several other industrialized countries (Premier's Council, 1991). Food supplements to mothers and school breakfast programs have been recognized as two effective means of improving the health of low-income children.

Economic downturns also lead to an increased likelihood of violence against women. Since November 1988, thirteen women have been murdered in Nova Scotia and five women have survived attempted murder. Women's groups report that at least one in ten women is battered by her male partner, with almost half of these women sustaining serious physical injuries. Eighty per cent of the women in the labour force have experienced sexual harassment at some time in their working lives (Transition House Association of Nova Scotia, et al.). Public education and increased funding for services for women victims and male abusers have been advocated.

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Another important area where social policy affects health is in the treatment of persons from minority groups. The Nova Scotia Advisory Group on Race Relations concluded in its September 1, 1991 report that overt and subtle discriminatory practices have prevented Black people from receiving equal services and opportunities (Nova Scotia Advisory Group, 1991). Similarly, half the health care workers surveyed for the Nova Scotia Council for Multicultural Health had experienced difficulties in treating minorities (Chronicle-Herald, Nov. 25/91). Ongoing cross-cultural and anti-racism training for government employees and service providers as well as funding for special outreach programs for drug awareness and prevention within the Black community have been identified as two more areas where policies are needed to counter these problems.

There are thus a wide range of social policies that could help improve the health of Nova Scotians. As an example, in Ontario, the Premier's Council on Health Strategy identified healthy child development policy and labour market adjustment policy as two important types of social policies needed to nurture health (Province of Ontario, Premier's Council, 1991).

D. Physical Environmental Policies

Nova Scotians are increasingly concerned about conditions in their physical environment. There are a number of troublesome environmental situations in the province.

From 1987 to 1989, there have been 11,000 to 13,000 time-loss injuries to Nova Scotians on the job (Statistics Canada, Feb. 1991). Related to these figures is a 33 per cent increase in new Workers Compensation claims from 1988 to 1990, that is, from 27,963 in 1988 to 42,104 in 1990 (Workers Compensation Board, 1988 and 1991). It seems apparent that much more needs to be done to improve occupational health and safety practices in this province.

Fears about environmental degradation and contamination have constantly been on the minds of Nova Scotians. Such infamous problems as: the continued seeping of 38 million gallons of raw sewage into Halifax Harbour every day; the Sydney Tar Ponds, the biggest toxic dump in eastern Canada; and the constant outflow of 23 million gallons of partially treated effluent every day at Boat Harbour, from the Scott Maritimes kraft paper mill in Abercrombie. While extensive clean-up operations are being planned or are about to get underway at all three locations, widespread public concern remains about the timing and extent of these measures and the ongoing health and environmental impacts.

In addition, the current state of our air, water and other natural resources continues to arouse public concern. For example, the Minister's Task Force on Clean Water reported that of the 81 municipal water supplies in the province, serving over 60 per cent of the population 67 have quality problems (48 of the 56 surface water supplies and 19 of the 25 groundwater supplies Minister's Task Force, 1991). High contaminant levels in the LaHave and Annapolis Rivers, fish kills in various rivers such as the East River in Pictou County, as well as the presence of chemical fertilizer and pesticide residues in some Valley wells are further examples of ongoing environmental problems.

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While these problems may well be addressed through the implementation of the Minister's Task Force on Clean Water and a Sustainable Development Strategy, the short-term and long-term consequences for health need to be assessed and considered as well.

E. Collaboration and Participation Policies

The Royal Commission spoke of a "new planning dynamic" required to achieve more responsive and responsible planning and administrative structures that will help improve health. As suggested by the Royal Commission, an intersectoral approach and public participation are essential parts of such a dynamic (Province of Nova Scotia, *Report of the Royal Commission,* 1989).

In recognition of the wide array of possible influences on health, it is essential that a number of different disciplines, departments, agencies and organizations, at all levels, work together in close collaboration. What is envisioned is nothing short of a complete integration of health planning into almost every arena of public policy development. The aim is, in other words, healthy public policy.

It is increasingly recognized that public participation (especially by patients and users) in the planning and management of health care and other human services is not just a frill but a vital necessity if these services are to respond to local needs as effectively and as efficiently as possible. However, there does seem to be wide variation in what is meant by public participation and how it is encouraged and sustained.

Klein describes at least five different levels of patient involvement including information, consultation, negotiation, participation and veto-participation (Klein, 1974). Each of these forms of participation or involvement may be useful at different times depending on the type of setting and the kind of issues involved. What is stressed by many writers is that a "bottom-up" and not a "top-down" approach is essential for a sense of community ownership and/or broad-based participation (Rachlis and Kushner, 1989; Clague, et al., 1984).

Another important aspect of participation in health planning is the role of service providers. Apart from physicians, these service providers have only been given limited opportunities for such participation, even though it is recognized that they have valuable insights to contribute. How extensive should provider participation be, at what levels, and how should it be encouraged so that relevant matters are addressed?

F. Technology Assessment Policies

The imbalance in resources for high technology services that benefit a few, contrasted with low technology primary care and health promotion which can benefit many, is a crucial question to be addressed (Province of Nova Scotia, *Report of the Royal Commission,* 1989). The Royal Commission recommended a managed approach within the context of a coherent policy framework, to the acquisition and use of technology. As stressed by the Royal Commission, the introduction of expensive new technologies is forcing policy makers to set

priorities in a time of scarce dollars and fiscal restraint. Therefore, the driving forces behind technology acquisition, needs and priorities, must be considered as part of a Comprehensive Health Strategy framework.

The Royal Commission and the *Health Strategy for the Nineties* both recommended that the Provincial Health Council establish a Standing Committee on Technology Assessment, which has been done (Province of Nova Scotia, *Report of the Royal Commission,* 1989; Province of Nova Scotia, *Health Strategy for the Nineties,* 1990). The Royal Commission also recommended that when the appropriate framework is in place, funding not be given to hospitals or physicians for use of unapproved technology (Province of Nova Scotia, *Report of the Royal Commission,* 1989). At present, provincial funding is provided for operating costs of hospitals without any apparent consideration of the technologies to be used. In fact, hospitals are encouraged to raise funding for special pieces of equipment on their own.

There is a Canadian Coordinating Office for Health Technology Assessment, and there are technology assessment committees or organizations being established in other provinces, but this area of health policy is clearly quite new and uncharted.

At the same time, it is recognized that technologies involving advanced communications and data processing could greatly assist health service providers and enhance public participation. Clague, et al. are especially enthusiastic about a number of positive benefits in the use of technology for such purposes (Clague, et al., 1984).

G. Innovation and Evaluation Policies

Related to the limited experience with technology assessment is the overall lack of research and evaluation in health and related human services. Rachlis and Kushner concluded that doctors have a poor understanding of statistics and that epidemiological research is grossly underused in health care. They also noted that there are few quality-assurance systems in the country and there are no clear lines of responsibility for who is in charge of getting such systems established (Rachlis and Kushner, 1989).

Furthermore, there are a lot of unknowns in the area of healthy public policy. The federal Health Services and Promotion Division cites at least seven areas where much more research is needed, including descriptions of existing healthy public policy, the effects and impacts of healthy public policy, the effects of context upon implementation, and the co-ordinating mechanisms (Government of Canada, Health and Welfare Canada, Health Services and Promotion, 1988). Clague, et al., recommended an independent centre for evaluation in human services in their province of British Columbia. Clague, et al., 1984).

Besides the need for much more research and evaluation activity, there is clearly a need to explore ways of encouraging innovation and progressive changes in the delivery of health-related services. Rachlis and Kushner suggested providing funding to hospitals and other institutions based on the quality of care they provide and how well they meet the acute care needs of the

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communities they serve (Rachlis and Kushner, 1989). Perhaps a more relevant question is what can be done to encourage and sustain innovation by all persons concerned with improving health, and not only at the institutional level.

H. Intergovernmental Policies

The policies and directions being taken by the federal government and other provinces and territories have direct and indirect impact on Nova Scotia's health policies. In fact, many of the policy changes needed to improve health do not lie within any one province and require intergovernmental coordination and action.

Although the delivery of health-related services falls under provincial jurisdiction, the federal government has long played a crucial role in their development. As noted by the National Council on Welfare, the federal government played a key role in getting medicare established in all provinces and territories, especially by means of its spending powers, but also in setting national standards (Government of Canada, National Council on Welfare, 1990). It also plays an important role in the funding and standards of social services through the Canada Assistance Plan (CAP).

The impact, since 1986, of unilateral decisions by the federal government to significantly cut its cash contributions to health and post-secondary education and to limit its expenditures under the Canada Assistance Plan, is becoming clear. If present trends continue, there will be no federal cash transfers for health care by about the year 2008 (Government of Canada, National Council on Welfare, 1991). Many prominent national groups strongly fear that this could mean the end of medicare as we know it.

Related to these federal cutbacks are federal constitutional proposals to reshape federal-provincial powers. Thus, many health-related areas of shared jurisdiction, such as job training, culture, housing, recreation, and urban and municipal affairs, would fall exclusively under provincial jurisdiction. At the same time, the possible health-related consequences of a national economic union do not appear to be fully determined (Government of Canada, *Shaping Canada's Future Together Proposals,* 1991).

In response to these developments, the Nova Scotia Working Committee on the Constitution reported that Nova Scotians do not want any decentralization of powers that would weaken the capacity of the federal government to meet the needs of all provinces and to be able to set national standards (Province of Nova Scotia, Nova Scotia Working Committee on the Constitution, 1991).

An alternative constitutional proposal with respect to social programs has been proposed by the Government of Ontario. They have proposed that a social charter, to protect and enhance the existing network of social programs, be entrenched in the constitution (Government of Ontario, *A Canadian Social Charter,* 1991).

Recently, there has been much talk and some initial steps taken towards Maritime or Atlantic economic integration. The Atlantic Provinces Economic Council (APEC) sees a number of possible new areas where there could be greater co-operation affecting health care, such as advocacy, procurement

and research, but they caution that co-operation is no panacea to the difficulties facing health care (Morely, 1991).

Another important area for federal-provincial/territorial action is that of comprehensive health human resource planning. The Royal Commission recommended that such planning be given the highest priority and take into account present and future health needs and alternate modes of service delivery (Province of Nova Scotia, *Report of the Royal Commission*, 1989). To do so effectively, coordinated planning must take place at the national level; this applies especially to the rate of growth in the number of physicians, which has been much higher than the overall rate of growth in the population as a whole. The Barer-Stoddart Report, prepared for deputy ministers of health across the country, is a major contribution towards establishing a comprehensive set of national resource policies for physicians (Barer and Stoddart, 1991).

Another level of needed intergovernmental cooperation and coordination is that of provincial-municipal relations. For several years, there have been discussions between the two levels of government in Nova Scotia about the provincial government assuming full responsibility for the costs related to human services such as community and social assistance services. In return, municipalities would take over the cost of property-related services. At the time of writing, discussions are still taking place about one possible move in this direction with the removal of a cap on provincial cost-sharing of social assistance spending, in return for municipalities assuming the cost of RCMP policing services in their areas.

I. Resource Allocation and Acquisition Policies

The Royal Commission concluded that Nova Scotia's health system is, as a whole, adequately funded, but that existing financial resources need to be redistributed more equitably and managed more effectively. The Commission called for funding structures and financial incentives to foster the use of alternate and less expensive modes of delivering health care (Province of Nova Scotia, *Report of the Royal Commission*, 1989).

Health care spending is the single largest area of provincial expenditure at about $1.3 billion or 28 per cent of the total provincial expenditure (estimated for 1991-92). Approximately 80 per cent of this is spent on hospitals, doctors' fees and drugs. At the same time only 3 per cent is spent on health promotion and community-based programs.

Currently, most health-related dollars are raised from federal cost-sharing and provincial tax revenue. Federal cost-sharing represents about 39 per cent of total gross provincial revenues. However, the dollar value of the Established Programs Financing (EPF), which is the main federal funding program for health care, has decreased in the last two fiscal years from $272 million in 1989-90 to $248 million in 1991-92. By 1994-95, it is expected that the cumulative loss in federal payments under EPF will have reached $1.5 billion, while the cap on equalization payments has cost Nova Scotia about $250 million between 1988-89 and 1991-92 (Province of Nova Scotia, *Budget Address*, 1991; Province of Nova Scotia, Return to House Order No. 217).

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In general, apart from federal transfer payments, income tax revenue and the Health Services Tax are the two biggest sources of provincial revenue. Income tax revenues provide about 26 per cent of total gross revenues in 1991-92 and the Health Services Tax provides about 16 per cent of total gross revenues. The two revenue sources have accounted for between 41 and 44 per cent of total gross revenues over the last five years (Province of Nova Scotia, *Budget Address*, 1991).

Health Strategy for the Nineties recommended that funding for community health programs be increased from 2.2 per cent to 4 per cent within five years. This will be achieved by an internal reallocation of the Department of Health's budget (Province of Nova Scotia, *Health Strategy for the Nineties*, 1990).

The Royal Commission warned that if current trends continue and no changes are made to restructure the planning of health programs, health care spending could exceed 35 per cent of total provincial spending by 2001 (Province of Nova Scotia, *Report of the Royal Commission*, 1989).

Ongoing debates have taken place over the last several years about the need for some sort of user fees. On the one hand, they are promoted as one means of raising additional funds and controlling consumer demand. On the other hand, they are opposed for failing to control inappropriate use of the health care system and for adversely affecting the health of persons on low and fixed incomes. They are now in place for some services such as the Pharmacare program and ambulance services.

IV. Conclusion

The Royal Commission on Health Care called for a new health strategy and a new planning dynamic. The newly-established Provincial Health Council has developed a new working definition of health. It is now presenting a discussion paper on the possible components of a framework for a Comprehensive Health Strategy.

It is hoped that this paper will encourage widespread consideration of both the breadth and content of such a framework, to help move closer towards the development of health goals for Nova Scotia.

Draft Health Goals

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Draft Goal – **Environment**

To preserve and enhance the physical environments of Nova Scotia to make all aspects of living supportive of health.

Draft Goal – **Governance**

To ensure that Nova Scotians can meaningfully participate in the development of and decisions about public policies and programs that affect health and the health care system.

Draft Goal – **Health Status**

To improve the health of Nova Scotians through a decrease in preventable illness, injury, and premature death and through the enhancement of markers of well-being.

Draft Goal – **Individual**

To enhance the capacity of Nova Scotians to understand and favourably influence the factors that affect health.

Draft Goal – **Resources**

To ensure that appropriate public resources, as determined by Nova Scotians, are allocated to the achievement of health goals and are managed in a fair, effective and efficient manner.

Draft Goal – **Social**

To strengthen the capacity of Nova Scotia to ensure social justice and provide adequate opportunities to achieve equity in health.

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Appendix A

Health Goals Elsewhere

Several other jurisdictions have developed health goals and a framework for comprehensive health planning. These are outlined below.

Premier's Council on Health Strategy

(Government of New Brunswick, 1990)

Goal 1 To increase the number of years residents of New Brunswick live free of major disease, disability and handicap.

Goal 2 To increase emphasis on health promotion and disease prevention.

Goal 3 To achieve and maintain healthy, strong and supportive individuals, families and communities.

Goal 4 To support the creation of healthier environments for all New Brunswickers.

Goal 5 To maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.

Improving Health and Well-Being in Quebec: Orientations

(ministère de la Santé et des Services Sociaux, 1989).

Goal – **Adding Years to Life**

Objectives:

1 Reduce cardiovascular-related deaths by 20 per cent between now and the year 2000

2 Reduce mortality due to breast cancer by 20 per cent and halt the increase in deaths due to lung cancer by the year 2000

3 Reduce traffic fatalities by 35 per cent between now and the year 2000

4 Reduce the number of suicides, particularly among young people, by 25 per cent between now and the year 2000

5 Reduce the perinatal mortality rate to 6 per 1000 live births by the year 2000

6 Stabilize the progression of AIDS related deaths by the year 2000

Goal – **Adding Health to Life**

Objectives:

7 Reduce by 10% the prevalence of backache by the year 2000.

8 Stabilize the spread of sexually transmitted diseases by the year 2000.

9 Increase the proportion of non-smokers to 80 per cent by the year 2000.

10 Reduce per capita alcohol consumption by 15 per cent by the year 2000.

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11 By the year 2000:
- Reduce sugar consumption by 50 per cent
- Reduce fat consumption to 30 per cent of total calories consumed.
- Increase consumption of carbohydrates to 50 per cent of total calories consumed.
- Increase fibre consumption.

12 Increase the proportion of the population that engages in physical activity to 60 per cent by the year 2000.

13 Help reduce environmental risks affecting health.

Goal – **Adding Well-Being to Life**

Objectives:

14 Encourage the autonomy of the elderly

15 Encourage the autonomy of people with physical, mental or intellec tual impairments.

16 Offer anyone who is mentally disturbed the chance to obtain a response adapted to his/her needs. Encourage the maintenance and optimal development of the population's mental health.

17 Reduce the incidence and consequences of child abuse and neglect.

18 Reduce the incidence and consequences of domestic violence.

19 Reduce the incidence and consequences of abuse.

Health for All Ontario (Ontario Health Goals Panel, 1987)

Goal 1 Achieve equity in health opportunities.

Goal 2 Enable Ontarians to achieve their health potential.

Goal 3 Increase the health expectancy of Ontarians.

Goal 4 Provide environments which support health.

Goal 5 Encourage behaviours which support health.

Goal 6 Provide health services which support health.

Goal 7 Establish public policy which supports health.

A Vision of Health Goals for Ontario
(Premier's Council on Health Strategy, 1991)

Goal 1 Shift the emphasis to health promotion and disease prevention.

Goal 2 Foster strong and supportive families and communities.

Goal 3 Ensure a safe, high quality physical environment.

Goal 4 Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

Goal 5 Provide accessible, affordable, appropriate health services for all.

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Questionnaire

Questionnaire On The Draft Health Goals

1 a. Do you understand each of the draft Health Goals? ❑ Yes ❑ No

b. If No, what part is hard to understand? (Please be specific.)

2 a. Do you agree with what each draft Health Goal says? ❑ Yes ❑ No

b. If No, what changes are needed? (Please be specific.)

3 a. Are there any Health Goals (not mentioned here) that you think should be included? ❑ Yes ❑ No

b. If Yes, what are they? (Please be specific.)

4 Can you suggest some key objectives for any of these Draft Goals?

Draft Goal – Environment:

Draft Goal – Governance:

Draft Goal – Health Status:

Draft Goal – Individual:

Draft Goal – Resources:

Draft Goal – Social:

5 Other Comments:

If you would like to receive a summary of the reactions which the Provincial Health Council receives on the draft goals, please give your name and mailing address:

Name:

Mailing Address:

Thank you for taking the time to answer these questions.

Please detach this questionnaire, when completed, and return to:

Provincial Health Council
Suite 406,1660 Hollis Street
Halifax, N.S. B3J 1V7
(Fax) (902) 424-0598

Please detach or photocopy for submission